DCH/LOS-502 (11/04)

Michigan Department of Community Health
Board of Osteopathic Medicine and Surgery
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918

EDUCATIONAL LIMITED LICENSURE INSTRUCTIONS OSTEOPATHIC MEDICINE AND SURGERY

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Osteopathic Medicine and Surgery. Questions regarding your application can be directed to the Osteopathic Medicine and Surgery at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

EDUCATIONAL LIMITED LICENSES

The Administrative Rules of the Michigan Board of Osteopathic Medicine and Surgery require an applicant for an Educational Limited license to be appointed to an AOA approved program **OR** have verification that they have completed an AOA approved internship.

INTERNS – The following must be received in the Board office:

1. Application and required fee. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid. An Educational Limited license may be renewed a maximum of 5 times, with no extensions available. An Educational Limited license is renewed each year on June 30.

2. Final, official transcripts, requested by you and sent directly to this office from your school, showing the degree earned and the date conferred. If final transcripts are not available, an official letter of good standing from your Dean or Program Director may be substituted. This letter cannot be written more than 90 days prior to your date of graduation. Final, official transcripts will be required before you can upgrade to a full license.

3. Certification of Appointment to Training Program form that is mailed directly to this office from the institution where you have been appointed to Board-approved post-graduate internship training.

RESIDENTS – The following must be received in the Board office:

1. Application and required fee. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid. An Educational Limited license may be held for a maximum of 5 years, with no extensions available. An Educational Limited license is renewed each year on June 30.

2. Final, official transcripts, requested by you and sent directly to this office from your school, showing the degree earned and the date conferred. If final transcripts are not available, an official letter of good standing from your Dean or Program Director may be substituted. This letter cannot be written more than 90 days prior to your date of graduation. Final, official transcripts will be required before you an upgrade to a full license.

3. Certification of Appointment to Training Program form that is mailed directly to this office from the institution where you have been appointed to Board-approved post-graduate residency training.

4. Verification of the completion of one year of AOA approved post-graduate internship training that is forwarded directly to this office from the training hospital on the Certification of Internship form (attached). **If the internship you completed was in an allopathic facility, you must contact the AOA to request approval of the program. If approved, the AOA must submit a letter directly to this office verifying the program's approval. If the osteopathic internship you completed was prior to 1988, you must contact the AOA and request a letter from the AOA be submitted directly to this office verifying the program's approval.**

5. Verification of license from each state where you hold or have ever held a full license. You are responsible for completing Part I of the enclosed Verification of Licensure form and submitting it to each state where you hold or have ever held a license to practice osteopathic medicine and surgery. This form must be submitted to the Michigan board directly from the state that is providing the verification. Most licensing agencies charge a fee for this service. The Verification of Licensure form may be duplicated if necessary.

GENERAL INFORMATION

1. NAME CHANGES: If your name changes please notify the Board of Osteopathic Medicine and Surgery in writing. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.

2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Osteopathic Medicine and Surgery in writing to request a refund.

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APPLICATION FOR EDUCATIONAL LIMITED AND CONTROLLED SUBSTANCE LICENSES

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, a license will not be issued

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone (313)-234-4300).

Board Use Only
License Number
CS License Number
Date of Licensure

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

☐ **Educational Limited and Controlled Substance Fee: $170.00 71 - 5101- 375705**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name

U.S. Social Security Number	Date of Birth	Daytime Phone Number

Have you ever held a health professional license in Michigan? ☐ Yes ☐ No	Michigan Permanent I.D. Number and Expiration Date

All Previous Names and/or Birth Name Used (if applicable)

Name of Appointing Hospital	Hospital Street Address	

City	State	ZIP Code

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. **Have you ever been convicted of a felony?**	☐ Yes	☐ No
2. **Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years?**	☐ Yes	☐ No
3. **Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?**	☐ Yes	☐ No
4. **Have you been treated for substance abuse in the past 2 years?**	☐ Yes	☐ No
5. **Have you had 3 or more malpractice settlements, awards, or judgments totaling $200,000 in any consecutive 5 year period?**	☐ Yes	☐ No
6. **Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?**	☐ Yes	☐ No
7. **Have you ever had a federal or state osteopathic license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?**	☐ Yes	☐ No
8. **Have you ever been censured, or requested to withdraw from a health care facility's staff or had your heath care facility staff privilege involuntarily modified?**	☐ Yes	☐ No

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

9. Do you hold or have you held a medical license in any state? If yes, list each state, the license or registration number, the date issued, and how the license was obtained. DO NOT LIST TEMPORARY LICENSES. **You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)** ☐ Yes ☐ No

State	License Number	Date of Issue	How Obtained (Endorsement or Examination)

Provide a complete chronological record of your educational preparation.
Attach additional sheets if necessary

Name and Address of Institution	Dates of Attendance From	To	Degree

Provide a description of your intern training experience.
Attach additional sheets if necessary

Name and Address of Hospital	Dates of Practice From	To	Program Title

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

Michigan Department of Community Health
Board of Osteopathic Medicine and Surgery
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

CERTIFICATION OF INTERNSHIP

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Medical Director or Superintendent of the training hospital where you served your internship. This certification must be submitted directly to the Michigan Board of Osteopathic Medicine and Surgery by the Director of the training program.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Social Security Number		Date of Birth
Hospital Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Name of Hospital

Signature of Applicant	Date

Applicant: **Upon completion of Section I, send this form to the Medical Director or Superintendent of the training hospital where you served your internship for completion of Section II.**

Name

THIS SIDE TO BE COMPLETED BY THE MEDICAL DIRECTOR OR SUPERINTENDENT

SECTION II - CERTIFICATION OF INTERNSHIP

Please complete the following information. Return this completed certification directly to the Michigan Board of Osteopathic Medicine and Surgery at the address shown on the reverse side of this form.

Name of Hospital		
Street Address of Hospital		
City	State	Zip Code

Is this internship AOA approved?

☐ Yes ☐ No

I certify that _____
(Applicant's Name)

has completed one year of internship at the above named hospital beginning _____
(Month/Day/Year)

and ending _____.
(Month/Day/Year)

I certify that this internship is one year in duration; of a rotating type, with rotations in the organized departments of Medicine, Surgery, Obstetrics and Gynecology; and that this Hospital is currently approved for the training of interns by the American Osteopathic Association. I further certify that the above named physician has served an apportioned time in each of the named rotations and has satisfactorily performed his/her duties.

_____
Signature of Medical Director or Superintendent

_____ _____
Print or Type Name Date of Signature

_____ (S E A L)
Title

If hospital has no seal, please indicate

IMPORTANT: This certification may not be dated and submitted more than fifteen (15) days prior to the completion of a full year's internship.

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CERTIFICATION OF APPOINTMENT TO A MICHIGAN TRAINING PROGRAM

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Program Director or Superintendent of the Michigan training hospital where you have been appointed. This certification must be completed and submitted to the Board of Osteopathic Medicine and Surgery by the hospital.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name

Social Security Number	Date of Birth

Hospital Street Address		

City	State	ZIP Code

Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)

Program (Internship or Residency)

Name of Hospital

Signature of Applicant	Date

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE PROGRAM DIRECTOR OR SUPERINTENDENT FOR COMPLETION OF SECTION II.

Name

THIS SIDE TO BE COMPLETED BY THE PROGRAM DIRECTOR/SUPERINTENDENT

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board Osteopathic Medicine at the address shown on the reverse side of this form.

SECTION II - CERTIFICATION OF APPOINTMENT

Name of Training Hospital		
Street Address of Training Hospital		
City	State	ZIP Code

Is this training program approved by the AOA?

☐ Yes ☐ No

I certify that _____ has been duly
(Applicant's Name)

appointed to the position of _____ in _____
(Internship or Residency) (Program)

at the hospital named above beginning _____ and ending _____.
(Month/Day/Year) (Month/Day/Year)

_____ _____
Signature of Director or Superintendent Date of Signature

_____
Print or Type Name of Director or Superintendent

(S E A L)

If school has no seal, please indicate.

_____
Title

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

DCH/HLD-001 (09/04)

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.

- ☐ Chiropractic
- ☐ Counseling
- ☐ Dentistry
- ☐ Marriage & Family Therapy
- ☐ Medicine
- ☐ Nursing
- ☐ Nursing Home Adm.
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Osteopathy
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physician's Assistants
- ☐ Podiatry
- ☐ Psychology
- ☐ Sanitarians
- ☐ Social Work
- ☐ Veterinary

First Name	Middle Name	Last Name
Previous Names Used	**Date of Birth**	**U. S. Social Security Number**
State Board	**License Number**	**Date of Issue**

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Type of License:	Original Issue Date	Expiration Date

Basis for Issuance of License:

☐ Examination - Please indicate type of exam (National, Regional, State, etc.) _____

☐ Endorsement - Please indicate name of state _____

License Status
☐ Current ☐ Lapsed ☐ Inactive

Has the applicant incurred any formal or informal actions in your State?
☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?
☐ No ☐ Yes

Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?
☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature **Date**

_____
Type or Print Name

(S E A L)

_____
Title

_____
Full Name of Licensing Board

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.